1800 INTRODUCTION

ADULT DAY HEALTH CARE

Nevada Medicaid reimburses for Adult Day Health Care Services that include medical or remedial services recommended by a physician or other licensed practitioner within their scope of practice for maximum reduction of physical or cognitive disabilities and restoration of a recipient to his or her best possible functioning level.

The goals of Adult Day Health Care services are:

a. to safeguard the recipient's safety and well being and maintain and/or enhance his/her quality of life; and

b. to improve and maintain the recipient's level of functioning or to lessen any decline in functioning due to disease and/or the aging process.

All providers participating in the Nevada Medicaid program must offer services in accordance with the rules and regulations of the Medicaid program.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up, with the exception of the four areas where Medicaid and Nevada Check Up policies differ as documented in Chapter 3700.

1801 AUTHORITY

Adult Day Health Care Services are provided by the Nevada Medicaid Program as an optional Medicaid state plan benefit as authorized by the Code of Federal Regulations (CFR), Part 42, 440.130 (d) Rehabilitative Services. Medicaid rehabilitation services must be recommended by a physician or other licensed practitioner of the healing arts, within the scope of practice under state law for the maximum reduction of a physical or cognitive disability and to restore the individual to the best possible functional level.

1802 DEFINITIONS

1802.1 ADULT DAY CARE FACILITY

Adult Day Care Facility is defined by Nevada Revised Statutes 449.004 as an establishment operated and maintained to provide care during the day, temporary or permanent, for aged or infirm persons, but does not include halfway houses for recovering alcoholics or drug abusers. Adult Day Care Facilities are required by Nevada Revised Statutes to be licensed by the Bureau of Licensure and Certification (BLC), Nevada State Health Division.

1802.2 ADULT DAY HEALTH CARE FACILITY

Adult Day Health Care Facilities provide medical services and oversight in addition to social, health and nutrition services. Adult Day Health Care (ADHC) consists of structured, comprehensive and continually supervised components that are provided in a protective setting. Recipients receive services and attend on a planned basis during specified hours. This establishment is licensed as an Adult Day Care Facility and meets the criteria set forth by Medicaid for reimbursement for Adult Day Health Care Services.

1803 POLICY

1803.1 ADULT DAY HEALTH CARE SERVICES

1803.1A COVERAGE AND LIMITATIONS

1. ELIGIBLE RECIPIENTS

Adult Day Health Care services are available to Medicaid eligible recipients with prior authorization who are age 18 or older. The individual must meet the level of care criteria for placement in a nursing facility and must require the medical and social services provided by Adult Day Health Care under a physician's order. The prior authorization of such individuals must include a rehabilitation goal to be met by Adult Day Health Care services. The individual must reside in an independent living arrangement.

An individual is not eligible if their residence is in a State licensed facility, i.e., Group Care, Assisted Living, or other type of residential facility where services similar to Adult Day Health Care are a requirement for licensure, or the facility is reimbursed for similar services by Medicaid or another State agency.

2. ELIGIBLE PROVIDERS

Adult Day Health Care facilities may receive reimbursement from Medicaid for the care and treatment of eligible persons as described if they are licensed and maintain licensure as an Adult Day Care Facility.

Medicaid will reimburse Adult Day Health Care facilities that meet and maintain compliance with the criteria set forth in the Medicaid Services Manual and maintain a current Medicaid Provider Agreement.

3. TRANSPORTATION

Medicaid will reimburse for transportation services as described in Medicaid Services Manual Chapter 1900.

1803.1B PROVIDER RESPONSIBILITIES

1. MEDICAID CONTRACT REQUIREMENTS

In order to qualify as a Medicaid provider, in addition to meeting and maintaining compliance with all state licensure regulations, the ADHC facility must provide the staffing and service requirements as outlined in 1803.1B(2) and (3) below. These

additional staffing and service requirements are necessary to ensure Medicaid recipients receive the necessary medical component of the licensed adult day care program.

After receiving a state license, the provider may submit an application to the QIO-like vendor to obtain a Medicaid contract.

As part of the contracting process, Medicaid staff will conduct an onsite review of the Adult Day Health Care facility to determine whether the additional requirements are met.

If the facility fails to meet the Medicaid requirements at the initial review or at any subsequent review, the facility will be notified and given thirty (30) days to comply. Otherwise, a Medicaid provider contract will not be issued or if already issued will be subject to termination.

Subsequent to the initial review, Medicaid may schedule an on site review at any given time without cause to assure the facility maintains compliance with the Medicaid criteria.

2. STAFFING REQUIREMENTS

An Adult Day Health Care facility must employ persons with the necessary education, skills and training to provide the Medicaid required services. Medical services must be provided by Nevada licensed/certified personnel.

a. REGISTERED NURSE

The facility must employ a Registered Nurse to oversee and provide medical services ordered by a physician. The RN must have at least one year experience in elder care or rehabilitation. The RN is responsible for conducting a recipient's health assessment within the first thirty days of enrollment and is responsible for developing the plan of care and the management of each recipient's care and treatment. An RN, or LPN under the supervision of an RN, will administer

medications provided to the recipient while in the facility's care. An RN, or LPN under the supervision of an RN, must be on duty during the hours in which a Medicaid Eligible recipient is in attendance at the facility.

b. PROGRAM DIRECTOR

The facility must employ a Program Director who has a minimum of 2 or more years of education and/or experience with elders and disabled individuals.

The duties of the Program Director will include at a minimum the development of plans and policies for the facility's operation, recruitment, employment and training of qualified staff, supervision and appropriate disciplinary action of staff, maintenance of employee and recipient information and records, maintenance of the facility's physical plant and housekeeping and nutritional services and the development and implementation of an evaluation plan of recipient services and outcomes.

c. OTHER STAFF

The facility must have direct care staff who observe the recipient's functioning and provide assistance to the recipient in the skills of daily living. Direct care staff must have education, experience and necessary qualifications to work with elderly and disabled individuals.

The facility must also provide for janitorial, housekeeping and activity staff or other staff as necessary to provide the required services and ensure each recipient's needs are met.

All staff must meet the Nevada Revised Statutes for certification, licensure and background status checks prior to employment.

3. SERVICES

The medical services ordered by a physician to be provided within the facility by the appropriate professional staff are:

a. Nursing services to include assessment, care planning, treatment, medication administration, evaluation and supervision of direct care staff

b. Restorative therapy and care

c. Nutritional assessment and planning

d. Non-medical services to be provided within the facility by appropriate professional staff include:

1. Case management to assist the recipient and family to access services needed by the recipient to maintain or improve their level of functioning or to minimize a decline in the level of functioning due to the progression of a disease or other condition that may not be remedied.

2. Recipient training in activities of daily living

3. Supervision and assistance to the recipient, to assure the recipient's wellbeing and that care is appropriate to the recipient's needs.

4. Social and recreational activities to enhance the recipient's functioning and/or to maintain or improve the recipient's quality of life.

4. PHYSICIAN EVALUATION AND ADMISSION ORDERS

Within six months prior to admission to a facility, a recipient must have undergone a physical examination and history by a medical doctor licensed to practice in Nevada. The physical and history may be completed by a Nevada licensed nurse practitioner or physician's assistant with physician oversight.

The physician's physical examination and history will include:

a. Primary and other significant diagnosis

b. Description of mental and physical disabilities

c. Nutritional status and needs

d. Medications prescribed and methods for administration

The physician must provide a written order for admission to an Adult Day Health Care Facility, which states the appropriateness of Adult Day Health Care in lieu of Nursing Home care and include all other relevant orders such as medications route of administration, dosage, frequency, treatments, therapies, etc.

The physician must re-evaluate the recipient's functioning and treatment needs and provide updated admission orders to the facility no less than every six months.

5. PLAN OF CARE

A written assessment of the recipient's physical, emotional and mental status and needs must be completed along with a plan of care as described in NAC 449. 4087-4088.

In addition to the requirements of NAC 449.4087, an assessment must address the recipient's medication regime, physical and cognitive status and need for nursing care and assistance. The assessment process is an interdisciplinary process including the recipient, the family or support person(s). The assessment must be reviewed and updated when there is a significant change of condition, and at least every six months.

The plan of care must meet the requirements of NAC 449.4088 and include objectives and directives for all medical treatment, medication administration and management, restorative therapy, social and recreational activities, case management and nutritional services.

The plan of care process is to be interdisciplinary and include the recipient when appropriate and his family or support person(s). An initial plan of care must be developed within 30 days after the admission of the recipient to the Adult Day Health Care facility. The plan of care must be re-evaluated at least every three months.

6. RECORD REQUIREMENTS

In compliance with NAC 449.40835, the facility must maintain records on each employee.

In compliance with NAC 449.40835, the facility must maintain records on recipients including daily progress notes. All entries made in the recipient's file must be signed and dated by the employee making the entry. The delivery of specific services including those required by Medicaid must be documented in the progress notes.

The Registered Nurse is responsible for the recipient's care and treatment and must review all progress notes.

The physician's orders must be signed and dated. Telephone orders must be initialed by the Registered Nurse upon receipt and signed by the physician within 10 days of the date of the order.

The facility must maintain an accurate record of the recipient's attendance. Attendance records must include the date and time of the recipient's arrival to the facility and the date and time of the recipient's departure from the facility. The record must also reflect any absence from the facility by the recipient for purposes of obtaining other services. This record is to include date, duration of absence and destination or purpose for absence.

The facility must maintain proof of each recipient's Medicaid eligibility. Verification of eligibility is the provider's responsibility. Eligibility should be verified monthly. Refer to Medicaid Services Manual, Chapter 100 for additional information regarding verification of eligibility.

7. CONFIDENTIALITY AND RELEASE OF RECIPIENT RECORDS

The facility is required to comply with applicable state and federal laws, rules and regulations regarding privacy and protection of an individual's health information.

1803.1C RECIPIENT RESPONSIBILITIES

Medicaid will reimburse Adult Day Health Care services, if state licensure and Medicaid requirements are met. The eligible Medicaid recipient and his family and/or support person(s) are responsible for:

1. Presenting any forms or identification necessary to utilize other health insurance coverage.

2. Making and keeping medical appointments as required and assisting the facility in obtaining necessary physician's orders.

3. Participating in care planning and facilitate recipient access to other needed medical and social services.

1803.1D PRIOR AUTHORIZATION AND BILLING

1. PRIOR AUTHORIZATION PROCEDURE:

Adult Day Health Care Services must be prior authorized (PA). The Adult Day Health Care provider must complete the "Adult Day Health Care Prior Authorization Request Form" and submit the request form and the required documentation to the QIO-like vendor before services are provided. All prior authorization requests must be complete and accurate and accompanied by a physician's order. If insufficient information is provided to support the completion of a request, the ADHC provider must supply the needed information within 24 hours of notification. When complete information is submitted, the QIO-like vendor will make a decision within five (5) business days.

In the case when an individual becomes eligible for Medicaid during the course of treatment or after services were provided, the ADHC provider may request a retro-eligible authorization by submitting the "Adult Day Health Care Prior Authorization Request Form" accompanied by the medical record including the physician's orders, care plan and progress notes encompassing the time period for which the authorization is requested.

The retro-eligible request must be submitted within ninety (90) days of the notice of decision. When complete information is submitted, the QIO-like vendor will make a determination within thirty (30) days.

a. Types of prior authorization requests include:
   1. Initial requests must be submitted before providing services to a Medicaid recipient for the first time.
   2. Continued service requests are required for ongoing services and must be submitted no less than five (5) working days before expiration of the previous authorized period.
   3. Interim requests when the provider is requesting a change in frequency or duration of services.
   4. Retro-eligible requests occur when an individual becomes eligible for Medicaid after services have been provided. Retro-eligible requests must be submitted within 90 days from the eligibility determination date (date of decision).

b. The prior authorization request must identify all of the following:
   1. The recipient meets a nursing facility level of care.
   2. Specific nursing services to be provided.
   3. Non-medical services to be provided.
   4. Recipient's rehabilitation goal(s);
   5. Frequency and duration of the requested services; and
   6. The request must include a copy of the physician's order.

Prior authorization may be approved for a maximum of 6 months. The length of time authorized is dependent upon the individual meeting medical necessity criteria. In order to extend payment when ongoing services are needed, the facility must submit a continued service request to the QIO-like vendor. Medicaid reimbursement is not available when the previous prior authorization date expires and a continued service request is not approved.

A prior authorization (PA) number is required on all claims and must correspond directly to all dates of service on the claim. No dates of service billed outside of the dates approved on the corresponding PA will be paid.

The QIO-like vendor will provide a written authorization to the Adult Day Health Care facility which includes a PA number and service authorization. The PA number must be included on all claims.

1804 HEARINGS

Please reference Nevada Medicaid's Manual Chapter 3100, for Medicaid Recipient Hearing and Grievances process policy.

1805 REFERENCES AND CROSS REFERENCES

Please consult other chapters of the Medicaid Service Manual which may correlate with Chapter 1800, Adult Day Health Care

a. Chapter 100, Eligibility Coverage and Limitations
b. Chapter 1900, Transportation
c. Chapter 3100, Hearings
d. Chapter 3600, Managed Care Organization
e. Chapter 3700, Nevada Check Up

1805.1 PROVIDER RELATIONS UNITS

Provider Relations Department
First Health Services Corporation
PO Box 30026
Reno, Nevada 89520-3026
Toll Free within Nevada (877) NEV-FHSC (638-3472)
Email: nevadamedicaid@fhsc.com

PRIOR AUTHORIZATION DEPARTMENTS

First Health Services Corporation
Nevada Medicaid and Nevada Check Up
HCM
4300 Cox Road
Glen Allen, VA 23060
(800) 525-2395

PHARMACY POINT-OF-SALE DEPARTMENT

First Health Services Corporation
Nevada Medicaid Paper Claims Processing Unit
PO Box C-85042
Richmond, VA 23261-5042
(800) 884-3238